

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 0 — 1 9

2. STATE:

OKLAHOMA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

10-07-2000

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 441.35

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-E, Page 1

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 1,602,900.00

b. FFY 2002 \$ 1,602,900.00

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Same page, Revosed 08-05-98, TN#98-14

10. SUBJECT OF AMENDMENT:

Expanding coverage of organ transplants

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ OTHER, AS SPECIFIED:☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Michael Fogarty

14. TITLE:

Chief Executive Officer

15. DATE SUBMITTED:

12-21-00

16. RETURN TO:

Oklahoma Health Care Authority

Attn: Billie Wright

4545 N. Lincoln, Suite 124

Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

12-22-00

18. DATE APPROVED:

02-14-01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10-07-00

20. SIGNATURE OF REGIONAL OFFICIAL:

Calvin G. Cline

21. TYPED NAME: Calvin G. Cline

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

c: Mike Fogarty
Jim Hancock
Billie Wright

State OKLAHOMA

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The following organ and tissue transplant procedures are covered:

1. bone marrow
2. stem cells
3. cornea
4. heart
5. kidney
6. liver
7. lung
8. simultaneous pancreas kidney (SPK)
9. pancreas after kidney (PAK)
10. heart-lung.

The following conditions must be met:

- a. all transplantation services, except kidney and cornea, must be prior authorized
- b. all procedures are reviewed and prior authorization is based upon appropriate medical criteria
- c. all organ transplants must be performed at a Medicare approved transplantation center
- d. procedures considered experimental or investigational are not covered.*

*(Transplantations which are considered experimental and/or investigational procedures by the Federal Department of Health and Human Services (DHHS) are not covered by the Agency's medical programs.)

Transplantations which are determined no longer experimental and/or investigational by DHHS will be reviewed by the Agency's Medical Advisory Committee and approved by the Agency's Board prior to coverage by the Agency's medical programs.

STATE	<u>Oklahoma</u>	A
DATE RECD	<u>12-23-00</u>	
DATE SENT	<u>02-14-01</u>	
DATE OF	<u>10-07-00</u>	
NOFA 179	<u>00-19</u>	

Revised 10-07-00

TN# 00-19 Approval Date 12-14-01 Effective Date 10-07-00
Supersedes
TN# 98-14-